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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF AMICUS CURIAE OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC. IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether Section 1 of the Sherman Act is violated when a qualified physician specializing in anesthesiology is excluded from appointment to the medical staff of a hospital solely because of an arrangement between the hospital and a group of anesthesiologists which eliminates competition in the provision of anesthesiology services by giving such group the exclusive right to provide such services to patients in the hospital.

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BRIEF AMICUS CURIAE OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC. IN SUPPORT OF RESPONDENT

The American Society of Anesthesiologists, Inc. ("ASA"), having obtained the written consent of all parties, respectfully submits this brief *amicus curiae* in support of the respondent, Edwin G. Hyde, M.D.

INTEREST OF AMICUS CURIAE

Founded in 1936, ASA is a national medical association composed of approximately 19,000 members, most of whom are physicians specializing in the practice of anesthesiology. Anesthesiology is a medical specialty involving the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and certain other medical procedures and the support of life functions under the stress of anesthetic and surgical manipulation,

as well as a range of other clinical applications of physiological and pharmacological expertise.

The purpose of ASA is to develop and further the specialty of anesthesiology for the general elevation of the standards of medical practice. In furtherance of this purpose, ASA has adopted a policy against contractual and other arrangements which limit patients' access to anesthesiologists on grounds other than qualifications and competence. (See ASA Statement of Policy set forth in Appendix A hereto.) In ASA's view, such arrangements deny physicians and patients the benefits of competitive development of the specialty of anesthesiology. The limits of modern surgery are defined by the advances in anesthesiology as a science and the ability of anesthesiologists to support life functions and manage the stresses experienced by patients during surgery. The complexities and high risks incident to modern anesthesiological care necessitate maintenance of an environment conducive to improvement and innovation—essentially through competitive development of the specialty. This is the interest which prompts ASA to file this brief *amicus curiae* in support of respondent in this case.

SUMMARY OF ARGUMENT

The holding of the court of appeals below that the exclusive contract for the provision of anesthesiological care at petitioner hospital constitued a tying arrangement in *per se* violation of Section 1 of the Sherman Act was clearly correct under the standards laid down by this Court. There can be no doubt that two distinct "products" are involved in this case—the clinical practice of medicine by the anesthesiologist (the "tied product") and hospital facilities and support services (the "tying product"). In hospitals such as the one involved in this case (which are unlike clinics), anesthesiological care is not provided by the institution itself; nor is such care sold to the institution for "resale" to surgeons and patients. The service is provided by independent physicians

directly to patients, and where possible, anesthesiologists actively compete to be selected by patients or by surgeons and other physicians acting on behalf of patients.

It is not essential to the establishment of a tying violation that petitioner hospital possessed dominant power in the market in which it operates (*i.e.*, the market for hospital services), but only that it possessed sufficient economic leverage to be able to impose the tie-in upon an appreciable number of patients or surgeons who might otherwise have preferred the service of an excluded anesthesiologist. It is clear that petitioner hospital possessed the requisite economic leverage. Hospitals are not fungible (whether viewed in terms of location, quality of staff, technological capacity, specialization or non-profit status), and the choice of a hospital must often precede or supersede the choice of an anesthesiologist, thus effectively limiting the market for anesthesiology services to the chosen hospital itself.

The challenged arrangement had precisely the sort of pernicious effects which the *per se* tying rule was designed to prevent. It enabled petitioner hospital to evade the provider reimbursement limits of third party payers by diverting to hospital revenues reimbursement designated for physician services. It preempted the preferences of patients, surgeons and other physicians in selecting among qualified anesthesiologists, and restricted the level of anesthesia care available at the hospital. It monopolized the tied product market for anesthesiology services at the hospital. The hospital's delegation to a group of anesthesiologists—in which the hospital had a financial stake—of power to exclude their otherwise qualified competitors from an essential facility constituted a classic group boycott. In addition, the arrangement confined the practice of the contracting anesthesiologists to petitioner hospital, thus magnifying the anticompetitive effect and extending it to other hospitals.

The justifications offered for the exclusive contract present no legitimate basis for avoidance of *per se* illegality. The purported justifications are founded merely on the administrative convenience of the hospital rather than patient welfare or the competitive position of the hospital, and could as well be accomplished through the less restrictive alternative of appropriate, objective criteria for the granting and renewal of hospital staff privileges to qualified physicians, including a requirement of adherence to appropriate medical staff bylaws, rules and regulations designed to assure quality of care and adequate physician availability.

The government seeks to save the arrangement by having this Court reverse its longstanding and well-founded tying doctrine. The government's proposal that tying arrangements be presumed procompetitive until they result in monopolization of both the tying and tied product markets is supported neither in law nor logic, and flies in the face of Congressional intent. Nor should this Court retreat from its *per se* prohibition of tying arrangements. This is not the case of a single buyer choosing to enter into a requirements contract where the anticompetitive effects are limited to the foreclosure of competing suppliers from that one buyer's patronage. Here a supplier is using its economic leverage in one product market to coerce and exploit consumers in another product market. This arrangement, like virtually all tying arrangements, strikes at the very heart of our competitive economy—the weighing by consumers of the relative merits of competing products—and (as petitioners proclaim) it threatens to proliferate. It is therefore properly subjected to the *per se* rule rather than analyzed under the rule of reason, which would require courts to undertake functions properly left to the market.

ARGUMENT

I. APPLICATION OF THE PER SE RULE TO THE CLASSIC TYING ARRANGEMENT PRESENTED IN THIS CASE WAS FAITHFUL TO THE STANDARDS LAID DOWN BY THIS COURT.

The court of appeals condemned as a *per se* violation of Section 1 of the Sherman Act an arrangement whereby petitioner East Jefferson Hospital (hereinafter "the Hospital") granted the exclusive privilege to practice anesthesiology at its facilities to a particular group of anesthesiologists (Roux & Associates), thus tying use of the Hospital's facilities to patronage of the Hospital-designated anesthesiologists, and excluding respondent, Dr. Hyde, from the practice of anesthesiology at the Hospital notwithstanding the recommendation of the Hospital medical staff that he be granted staff privileges. This holding is fully in accord with the relevant standards laid down by this Court. Indeed, the facts presented in this case amply bear out the wisdom of this Court's long-standing adherence to the *per se* rule in tying cases.

A. The Clinical Medical Services Provided by Independent Anesthesiologists Are Generically Different From the Facilities and Support Services Provided by the Hospital.

At the outset, petitioners and allied *amici* attempt to short-circuit application of the tying doctrine in this case by suggesting that the clinical practice of medicine by an anesthesiologist is insufficiently distinct from such hospital services as the provision of operating rooms, blood, oxygen, drugs and nurses to warrant antitrust concern with protecting a patient's or surgeon's choice of a particular anesthesiologist, or an anesthesiologist's ability to compete on equal terms for the patronage of patients or of surgeons acting on behalf of patients. *See* Brief for the Petitioners (hereinafter "Hosp. Br.") at 41. It is noteworthy that neither the district court nor the court of appeals below deemed there to be any issue

as to the distinct nature of clinical medical services vis-a-vis hospital services.[1]

Although case law provides guidance for determining whether products or services are sufficiently distinct to invoke the tying doctrine, the issue turns largely on conventional wisdom reflective of the realities of the marketplace.[2] In ASA's view, a proper disposition of this case depends in the first instance upon an appreciation of the realities of the service provided by the anesthesiologist and the marketplace in which he or she operates.

1. ***The anesthesiologist practices a broad range of clinical medicine (not limited to the operating room), and is therefore more akin to the surgeon than to the radiologist or pathologist.***

As noted at the outset, anesthesiology is a specialized practice of medicine encompassing a broad range of clinical roles. Although the anesthesiologist may most often be called upon to care for patients undergoing surgery or for mothers in childbirth, the practice of anesthesiology extends beyond the operating room and the obstetrical suite.[3] Anesthesiology involves the "clinical" practice of medicine in that the anesthesiologist is called upon to diagnose, treat and care for the patient directly.

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[1] *See* 686 F.2d 286, 289 (5th Cir. 1982) ("The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that . . . . we are dealing with two distinct services which a buyer should be able to obtain separately"). *See also* 513 F. Supp. 532, 540 (E.D. La. 1981).

[2] *See, e.g.*, R. Posner, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 181 (1976); Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 757 (1981); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

[3] The responsibilities of the anesthesiologist also include the management of patients unconscious from whatever cause; the alleviation of various pain states and the establishment of nerve blocks; respiratory care and the treatment of chronic respiratory diseases; cardiac and respiratory resuscitation (including the management of drug poisoning cases); and intravenous fluid therapy. *See* V. Collins, PRINCIPLES OF ANESTHESIOLOGY 28 (1976); *cf.* LAWYERS MEDICAL CYCLOPEDIA § 25.8a (1976 Supp.).

This is true in the surgical suite no less than in other areas of the anesthesiologist's practice.

Apart from technical skills in administering anesthesia,[4] the anesthesiologist must function as an effective diagnostician, pharmacologist and physiologist.[5] During surgery, the anesthesiologist functions as

> ". . . the medical internist in the operating room. . . . [H]e advises the surgeon concerning physiologic dysfunction, pharmacological aspects and the treatment of medical complications that arise in the patient during the course of anesthesia and surgery. His province and sphere of activity is thus clearly defined. It is to care for the physiological functions of the patient, thereby permitting the surgeon to devote and concentrate his entire attention and skill to the reestablishment and correction of anatomical abnormalities. Thus, the surgeon's skills are directed more toward anatomy, while the anesthesiologist's

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[4] The technical aspects of administering anesthesia may be delegated to a qualified nurse anesthetist acting under the medical direction of an anesthesiologist or, if no anesthesiologist is available, another qualified physician. Nurse anesthetists cannot, however, either by training or by licensure, perform the medical role of anesthesiologists. *See* 513 F. Supp. at 540 (district court opinion below); O'Meara, *Liability of the Anesthesiologist in the Hospital Environment*, Med. Trial Tech. Q. 420, 422 (Spring 1979). Data from the 1981 American Hospital Association Census of Hospitals indicates that anesthesia for surgery is administered in 27.5% of cases by anesthesiologists practicing alone, in 61% of cases in a "team" mode with an anesthesiologist medically directing nurse anesthetists, and in 9.3% of cases by a team consisting of a physician other than an anesthesiologist (usually a surgeon) medically directing a nurse anesthetist.

[5] *See* Collins, *supra* at 27. All anesthetics in common usage today are lethal if administered in sufficient quantity. It is the anesthesiologist's responsibility to conduct a preoperative evaluation of the patient in order to determine the patient's physical and mental tolerance for anesthesia and to prescribe an appropriate mix of drugs and method of administration. Post-surgical responsibilities include the management of the patient's recovery from anesthesia and the treatment of pain and any complications from anesthesia. *See* O'Meara, *supra*, at 428-429, 431-435.

skills are directed more toward the physiology." Collins, *supra*, at 27-28.

Indeed, the administration of anesthesia (*e.g.*, to an aged patient with a heart condition) may entail greater risk than the surgical procedure itself, such that the patient's welfare depends primarily upon the medical judgment and skills of the anesthesiologist.[6]

It is popular, but fundamentally misleading, to class anesthesiologists with pathologists and radiologists under the rubric of "hospital-based" physicians. Unlike anesthesiologists, pathologists and radiologists typically do not practice in a direct physician-patient relationship, but rather essentially provide service to clinical physicians through the utilization of the hospital's laboratories and x-ray equipment, and frequently do so as employees of the hospital.[7] For lack of a clinical practice, radiologists and

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[6] *See United States v. The American Society of Anesthesiologists*, 473 F. Supp. 147, 152 (S.D.N.Y. 1979).

[7] While such services depend upon complex and sensitive equipment, the care of which must be closely supervised (*see* American College of Pathologoists Brief at 11), anesthesiology is much less equipment-intensive. *See* Transcript of May 15, 1980 (morning) at 54; Transcript of May 16, 1980 at 34 (some anesthesiologists furnish their own equipment, gases and drugs).

According to one recent study, approximately seventy-eight percent of pathologists and fifty-eight percent of radiologists have some sort of financial relationship with a hospital; the comparative figure for anesthesiologists was only twenty-seven percent. *See* American Medical Association, Center for Health Policy Research, Socioeconomic Monitoring System ("SMS") Report (February 1982). Even these figures do not indicate that exclusive arrangements of the type at issue in this case are widespread. In fact, the SMS Report indicates that over half of the pathologists and thirty percent of the radiologists (as well as eighty-seven percent of the psychiatrists) having financial relationships with hospitals were on salary. As discussed *infra*, a salary arrangement cannot be equated with an exclusive contract of the type presented in this case. While a breakdown of anesthesiologists' financial arrangements with hospitals is not contained in the SMS Report, testimony below indicated that contractual relationships between hospitals and anesthesiologists in New Orleans were not necessarily "exclusive" in nature. *See* Transcript of May 16, 1980 at 25-26.

pathologists need not be based at a hospital in order to compete to provide services there.[8] On the other hand, surgeons are "hospital-based", but it is well-recognized that the clinical nature of the surgeon's practice, like that of the anesthesiologist, clearly demarcates such practice from support services provided by the hospital.

The nature of his clinical practice makes the anesthesiologist most vulnerable to exclusive contracts. Unlike the pathologist and radiologist, who may compete outside the hospital, the anesthesiologist must have privileges at a hospital in order to compete for the patronage of patients there. But unlike the surgeon, the anesthesiologist is not able himself to admit a potential patient to another hospital if he is excluded from the hospital of the patient's choice. Only after the hospital has been chosen on the basis of other factors does the choice of an anesthesiologist generally arise, and that choice is necessarily confined to those anesthesiologists who are permitted to practice at the chosen hospital. So far as the anesthesiologist is concerned, the hospital at which he has privileges is the marketplace and the market is the group of patients admitted to the hospital.

2. ***The requisite distinction between anesthesiology and hospital services is apparent from the fact that anesthesiology is provided by an economic actor independent of the hospital.***

Petitioners seek to avoid the commercial, practical and legal realities which distinguish anesthesiology from hospital support services by asserting that the anesthesiologist's services are functionally complementary and pro-

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[8] *See* College of American Pathologists Brief at 11 n.7 ("In the case of pathologists, . . . competition is provided by independent laboratories whose services compete with those offered in hospitals"); Hosp. Br. at A-3 (Federal Trade Commission advisory opinion on exclusive radiology contract noting that the hospital in question "accepts radiological studies from other hospitals or from independent laboratories at the discretion of the attending physician").

vided in fixed ratio to surgical services, and not provided independently thereof. *See* Hosp. Br. at 40. Even accepting petitioners' assertion at face value,[9] it rests on the erroneous premise that patients and surgeons are indifferent as to who performs the anesthesiology service. As recognized by the court below, 686 F.2d at 291-292, the record in this case amply reflects the fact that anesthesiologists—and the respondent, Dr. Hyde, in particular—do compete for patronage of patients, or for referral by surgeons or other physicians on behalf of patients, on the basis of individual competence, quality and manner of care.[10] The patient has a vital independent interest in choosing a preferred array of practitioners, settings and services. The patient should not have to confront a "Hobson's choice" of foregoing either his chosen practitioner or else his chosen therapeutic setting where a preferred anesthesiologist is excluded from a hospital only because of an exclusive contract. *See* Dolan & Ralston, *supra*, at 721, 777. The Hospital's claims of "complete functional integration" cannot overcome the fact that the exclusive contract in this case restricted the alternatives

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[9] As discussed above, the assertion is not factually accurate. Anesthesiologists provide many medical services unrelated to surgical services. Moreover, the extent of anesthesia services required for surgery varies, and bears no fixed relation to the extent of surgical service that may be required. *See United States v. The American Society of Anesthesiologists, supra*, 473 F. Supp. at 152-154.

[10] *See, e.g.*, Transcript of May 15, 1980 (afternoon) at 17, 20-21, 33-35, 64-65; Transcript of May 16, 1980 at 25-31, 33-34, 47-48, 64-65, 69, 73-74, 87-88, 110, 116-117.

Inasmuch as anesthesiology services are for the most part covered by health insurance, any price competition among anesthesiologists is primarily directed toward insurers rather than patients. *See United States v. The American Society of Anesthesiologists, supra*. But it is clear that the hospital is not (at least in the absence of an employment relationship) the purchaser of anesthesia services or the customer of the anesthesiologist. Nor can the hospital itself practice medicine.

sought by patients and surgeons and restrained competition among anesthesiologists at the Hospital.[11]

Petitioners seek to escape this fact by contending that the exclusive contract accomplished "vertical integration" or the "functional equivalent" of an employment contract. Hosp. Br. at 43-44. But the Hospital is not a clinic which itself provides medical care as well as hospital services. Rather, the commercial reality is that use of the Hospital's facilities was tied to use of services provided by an economic entity distinct from the Hospital itself. Just as in *Fortner Enterprises, Inc. v. United States Steel Corp.* ("Fortner I"), 394 U.S. 495 (1969), this reality dictates that "separate products" are involved. There the Court reasoned that while credit is normally viewed as an inseparable part of the purchase price of an item, this is not so

> "where the credit is *provided by one corporation on condition that a product be purchased from a separate corporation*, and where the borrower contracts to obtain a large sum of money over and above that needed to pay the seller for the physical product pur-

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[11] *See International Business Machines Corp. v. United States*, 298 U.S. 131 (1936) (lease of tabulating machines tied to the purchase of punch cards used solely with the machines); *International Salt Co. v. United States*, 332 U.S. 392 (1947) (purchase of salt-dissolving or -dispensing machines tied to purchase of salt). Indeed, the fact that the anesthesiologist's services are performed only in a hospital makes the tie more—rather than less—pernicious, since the exclusionary effect upon anesthesiologists will therefore be greater than otherwise. *See* Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1270-1271 (1980). Nor can petitioners blur the distinction between anesthesiology services and hospital services simply by asserting that economic efficiencies accrue to the hospital by virtue of the exclusive contract. *See* Hosp. Br. at 39. Such assertion is relevant, if at all, only to the affirmative defense that the tying arrangement was essential to protect the Hospital's "good-will"—an issue distinct from "product separability." See p. 22, *infra*.

> chased.[12] Whatever the standards for determining exactly when a transaction involves only a 'single product', *we cannot see how an arrangement such as that present in this case could ever be said to involve only a single product.*" 394 U.S. at 507 (emphasis added; footnote omitted).[13]

It is irrelevant that the hospital might not have violated the antitrust laws had it employed anesthesiologists under a salaried arrangement. This Court disposed of such an argument in *Standard Oil Co. of California v. United States*, 337 U.S. 293 (1949).[14] Moreover, as shown below, the particular contractual arrangement involved here enabled the Hospital to exploit purchasers in a way it would not have been able to had the anesthesiologists been employed by it.

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[12] Similarly, in this case the functional relationship between surgical services and anesthesia does not correspond to the full extent of the tying arrangement, whereby use of the Hospital's facilities required that any and all anesthesiology service (not just that restricted to surgical anesthesia) be provided by the franchised group.

[13] While the lending entity was a wholly-owned subsidiary of the manufacturer and was established solely to facilitate the sale of the latter's product, the Court recognized that defendants cannot escape antitrust liability by foreswearing the separate corporate forms in which they in fact operated. *Id.* at 507 n.4. The lower courts have focused on the fact of separate billing (as was the case at bar) in determining that allegedly tied products or services were in fact separate. *See United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961); *Associated Press v. Taft-Ingalls Corp.*, 340 F.2d 753, 764 (6th Cir.), *cert. denied*, 382 U.S. 820 (1965).

[14] "Though it may be that such an alternative to the present system as buying out independent dealers and making them dependent employees of [defendant] would be a greater detriment to the public interest than perpetuation of the system, this is an issue, like the choice between greater efficiency and freer competition, that has not been submitted to our decision." *Id.* at 311-312.

B. The Hospital Necessarily Possessed the Requisite Degree of Power Over the Tying Product to Trigger Application of the Per Se Rule.

The district court below plainly misapplied this Court's standards for determining whether a defendant possesses sufficient economic power in respect of a tying product to trigger the *per se* prohibition of tying arrangements. This Court has "made unmistakenly clear that the economic power over the tying product can be sufficient even though the power falls far short dominance . . . ." *Fortner I*, *supra*, 394 U.S. at 502-503. All that is required in this regard is that the Hospital possess sufficient economic leverage to impose a tie-in upon "any appreciable number of [patients] within the market," whether they be "few or many, whether scattered throughout the market or part of some group within the market", even though "[its] power is not complete over them . . . ." *Id.* at 503. "[T]he crucial economic power may be inferred from the tying product's desirability to consumers," *United States v. Loew's, Inc.*, 371 U.S. 38, 45 (1962), or from "some advantage not shared by . . . competitors," whether a cost advantage or an advantage "differentiating" the tying product, *United States Steel Corp. v. Fortner Enterprises, Inc.* ("Fortner II"), 429 U.S. 610, 620 (1977), such that " 'there are some buyers who find [the] seller's product uniquely attractive . . .' " *Id.* at 621 n.14 (citation omitted). Importantly, it is unnecessary to determine the defendant's market share in either the tying or tied product market in order to establish a *per se* tying violation.[15]

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[15] *See United States v. Loew's*, *supra*, 371 U.S. at 45 n.4; *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 9 (1958), *quoting Standard Oil Co. of California v. United States*, *supra*, 337 U.S. at 305. It is noteworthy that even accepting the narrowest definition of the relevant market proffered by petitioners, *see* Hosp. Br. at 30, the Hospital's market share would exceed the 6.7% share which was found sufficient under a more lenient standard to condemn requirements contracts in *Standard Oil*.

After observing that seventy percent of the Hospital's patients were residents of the East Bank of Jefferson Parish, the district court found that "[i]t is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family". 513 F. Supp. at 543. In view of the manifest market imperfection created by pervasive health insurance, the court of appeals was plainly correct in holding that this finding established sufficient economic power over the tying product to invoke the *per se* rule.[16]

Petitioners take issue with a second market imperfection cited by the court of appeals—"the lack of complete information regarding the quality of medical care offered" by different hospitals, 686 F.2d at 290—by arguing that "surgeons and other knowledgeable people almost always choose the hospital and anesthesiologists for surgery. . . ." Hosp. Br. at 33.[17] This begs the point. A hospital is generally chosen on the basis of many consid-

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[16] *See* Dolan & Ralston, *supra*, at 765-66 ("In a large city, it is unreasonable to group all hospitals into one geographic market, given the realities of intra-city transportation, community identification, and crime and safety issues"); Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 653 (1982) ("Hospitals . . . often may possess . . . market power because of a hospital's location . . . ."); *cf. Fortner I*, *supra*, 394 U.S. at 509 ("[a]lthough money is a fungible commodity . . . markets . . .are often imperfect . . . ."); *Fortner II*, *supra*, 429 U.S. at 620 (requisite power derives from lack of "completely competitive market").

[17] Similarly, the American Hospital Association asserts that while the location of a hospital is a factor weighed by patients, they "consider other variables as well, including quality, reputation and technological capacity." American Hospital Association Brief at 25-26. But these are simply varying factors which combine to form a patient's preference for a particular hospital, and it is such preferences which enable a hospital to retain some patients notwithstanding the exclusion of an anesthesiologist they might prefer. In this regard, there was testimony below that more difficult surgeries are performed at the Hospital and its anesthesia equipment is more complex. 513 F. Supp. at 538.

erations besides anesthesiology, with the result that the relevant market for anesthesiology services is effectively confined to those anesthesiologists permitted to practice at the chosen hospital. *See* p. 9, *supra*. The patient or surgeon will generally be constrained from switching to another hospital in order to obtain the services of a preferred anesthesiologist.

C. The Challenged Arrangement Had a Number of Plainly Anticompetitive Effects Which the Per Se Rule Is Designed to Prevent.

The fact that the arrangement at issue in this case involved the financial collusion of separate and independent providers of the tying and tied products has a significant bearing on its anticompetitive nature. It is recognized that one of the anticompetitive uses for tying arrangements "may be . . . to evade price control in the tying product through clandestine transfer of the profit to the tied product . . . ." *Fortner I*, *supra*, 394 U.S. at 513 (White, J., dissenting) (citation omitted). In the health care industry, cost containment efforts on the part of private and governmental third party payers has largely displaced traditional price competition as the mechanism for regulating the charges of health care providers.[18] According to one commentator well acquainted with the subject, the growth of arrangements of the type challenged in this case is linked to the cost containment efforts of third party payers, and the resultant incentive for hospitals to "divert a portion of the professional [physician] service fees for the hospital's administrative services." [19]

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[18] According to the American Hospital Association Brief (at 4a), third party payers recently "have sought a complete restructuring of hospital payment systems in order to impose some measure of price competition on their 'marketplace' for hospital services."

[19] Nord, *Antitrust Law and Exclusive Contracts: Obstacles to Patients' Benefits?*, Law, Med. & Health Care 66, 69 (April 1983). The author laments recent regulations issued under the Tax Equity and Fiscal Responsibility Act of 1982 which bar such diversion of

It is apparent that the Hospital employed a tying arrangement in order to avoid price controls on the tying (hospital) services by extracting added revenue from the tied (anesthesiology) services. Under the arrangement, although patients received a bill for anesthesia services from the Hospital which contained a separate charge for the medical service provided by the anesthesiologist, the Hospital kept 54 percent of all the anesthesia revenues for itself. This percentage was not correlated to Hospital costs (Transcript of May 15, 1980, morning, at 85-86), and generally resulted in profit to the Hospital. *See* 513 F. Supp. at 536.[20] As if to aid their case, petitioners point out that ultimate control over the level of the charges for anesthesiology services rested with the Hospital. Hosp. Br. at 3.[21] Thus, the Hospital used its lever-

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physician fees reimbursed under the federal Medicare program. According to the Department of Health & Human Services:

> "Some hospitals bill amounts for services of compensated physicians that exceed the compensation the physicians receive for the services. The inclusion in charges of amounts that exceed the physicians' compensation for the services *enables the hospital to realize a profit* from the services of compensated physicians. Our usual reasonable charge rules (under which carriers generally consider only the customary, prevailing and actual charges for services) have not been effective in preventing payment of *unreasonably high charges. Further, it is not reasonable to pay more for a service than the physician receives for furnishing it* . . . . Therefore, we believe it is necessary to recognize as reasonable only those charges that would return to the provider the cost of compensating the physician for the services being billed for." 48 F.R. 8914 (March 2, 1983) (emphasis added).

[20] Respondent resisted an identical arrangement because:

> ". . . it was a contract that indicated they were going to share in any revenues . . . . [T]o me, it indicated an attempt by the hospital to get into my particular private business and if they closed the anesthesia staff, why it wouldn't be too long before they wanted to close some other staffs." Transcript of May 16, 1980 at 75-76.

[21] In the absence of true vertical integration between the Hospital and the anesthesiologist group (a fact exploited by the Hospital),

age over the tying market not only to preempt patient/surgeon choice in the tied market, but also (by limiting the actual reimbursement of the anesthesiologists, but not the fees billed in their name) to overcharge health insurers who paid for the tied product.[22] The arrangement therefore fits the classic mold of a *per se* tying violation.[23]

Moreover, in return for entering into the financial arrangement, the anesthesiology group was awarded a complete monopoly over the tied product market for anesthesiology service.[24] As a result, in order to practice

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the arrangement appears to involve vertical price-fixing of a character more pernicious than the price-fixing condemned in *Arizona v. Maricopa County Medical Society*, 102 S.Ct. 2466 (1982).

[22] Thus, a crucial distinction between the arrangement at bar and a true employment relationship is that the arrangement hinged upon the receipt of third party reimbursement for physician billings, rather than physician salaries.

[23] *See, e.g., Atlantic Refining Co. v. Federal Trade Commission*, 381 U.S. 357 (1965) (arrangement between oil company and tire company whereby the former effectively conditioned the sale of its gasoline to dealers upon their purchase of tires from the latter, for which latter paid the oil company a commission, held equivalent to *per se* tying violation); *Federal Trade Commission v. Texaco, Inc.*, 393 U.S. 223 (1968) (similar). In rendering an advisory opinion on an exclusive radiology contract, the Federal Trade Commission declined to invoke the *per se* tying rule on the understanding that "the Hospital derives no direct exploitive financial benefit" from the contract. Hosp. Br. at A7-A8.

[24] *See* pp. 9, 14-15. The testimony of a former board member of the Hospital indicates that it was indeed to obtain "all of the rights and privileges of the monopoly . . . with the handsome income it was providing" which led Dr. Roux to tolerate "linkage or control with the hospital administration." Transcript of May 16, 1980 at 159. An analogous arrangement involving monopolization through contract was condemned in *Hecht v. Pro-Football, Inc.*, 570 F.2d 982, 992-993 & n.45 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978) ("when the restrictive covenant covers an essential facility . . . all possible competition is by definition excluded and the restraint is thus unreasonable *per se*—provided . . . that the facility can be shared practically"); *See also* Dolan & Ralston, *supra*, at 768-69 ("[O]btaining exclusive franchises [in hospitals is] plainly designed to exclude competitors. . . . [M]onopo-

at the hospital, any other anesthesiologist would have to be acceptable to (and likely have to buy into) the group, and be willing (as respondent was not) to submit to the financial arrangement. The Hospital's delegation to the group—in which the Hospital had a financial stake—of an arbitrary power to exclude the group's otherwise qualified competitors[25] from an essential facility constituted a classic group boycott.[26] By the same token, it cannot matter that the group secured its monopoly through a financial inducement rather than some form of coercion or control of the Hospital.[27]

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lization is an accurate characterization of 'what is really going on here.' ").

[25] The Hospital acknowledged that respondent would have been granted staff privileges had he been invited to join Roux & Associates. Transcript of May 15, 1980 (morning) at 18-19, 30-32.

[26] *See Associated Press v. United States*, 326 U.S. 1 (1945) (condemning news service bylaw permitting a member to block the membership application of a competitor); *American Medical Ass'n v. United States*, 317 U.S. 519 (1943) (conspiracy, *inter alia*, to deny hospital staff privileges to physicians pursuing disfavored financial mode of practice); *Fashion Originators' Guild of America, Inc. v. Federal Trade Commission*, 312 U.S. 457 (1941); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Silver v. New York Stock Exchange*, 373 U.S. 344, 361-367 (1963) (fair hearing must precede exclusion of competitors); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (third party payer requirement that psychologist services to be billed through a physician constituted boycott of independent psychologists); *Hecht v. Pro-Football, Inc., supra; Dolan & Ralston, supra* at 755 ("The application of the boycott theory to the hospital setting is manifest. *With franchises and staff size limits, the very purpose of the agreements is to exclude competitors*") (emphasis added); Kissam, Webber, Bigus & Holzgraefe, *supra* at 653 ("A system of exclusive privileges in each specialty would give each partnership the power to veto competitors who seek to join the hospital's staff. This situation is difficult to distinguish from the facts in *Associated Press v. United States*").

[27] While members of the group professed support of respondent's application to the Hospital in the belief that the contract was no longer exclusive after 1976, they were secure in the knowl-

The fact that other hospitals can and do emulate the practice cannot justify ignoring the effect of the tying arrangement on patients and anesthesiologists.[28] This Court prohibited *per se* an analogous arrangement in *Atlantic Refining Co. v. Federal Trade Commission*, *supra*, in part because of the "destructive effect . . . that would result from the widespread use of these contracts" to "sew up large markets." 381 U.S. at 371. In *Standard Oil Co. of California v. United States*, *supra*, 337 U.S. at 309, the Court similarly recognized that widespread use of requirements contracts would entrench established suppliers and hinder new competitors.[29]

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edge that the Hospital did not share such view, and their support of respondent did not extend to inviting him to join their group. *See* Transcript of May 15, 1980 (morning) 18-19, 30-32. Indeed, the group had an incentive to remain small enough to reap sufficient reward to offset the financial participation of the Hospital. Available medical care was necessarily diluted commensurately. Concern with adequate medical coverage apparently necessitated that the group agree to confine their practice to the Hospital, thus further magnifying the anticompetitive effect among anesthesiologists, and perhaps extending it to competing hospitals.

[28] *See* Hosp. Br. at 16-18. In this regard, petitioners misconstrue the Court's opinion in *Fortner II*, where the crucial fact was that defendant lacked any advantage with respect to the tying product (*i.e.*, credit, an essentially fungible commodity) which could not readily be matched by competitors through price competition. Hospitals, by contrast, are hardly fungible from the patient/surgeon's point of view, and are not generally chosen on the basis of price. See p. 14 & n.17, *supra*.

[29] According to one commentator, increased entry of physicians into the medical marketplace in recent years has created an administrative burden for hospitals, and the "easiest, least costly solution to this problem for hospitals will be more contracts with exclusive requirements . . . with specific physician groups." Nord, *supra*, at 68. The opinion in *Standard Oil* precludes any such justification for exclusive contracts:

> "If indeed, this [barriers to entry into the market] were a result of the system, it would seem unimportant that a short-run by-product of stability may have been greater efficiency and lower costs, for it is the theory of the antitrust laws that the long-run advantage of the community depends upon the

Nor does it aid petitioners to suggest that anesthesiologists might compete for exclusive contracts. It is not apparent how any such competition—which would involve only uncommitted groups and, as a practical matter, preclude solo practitioners at most hospitals—could be conducted on the basis of bona fide quality considerations.[30] Such "franchise competition" would amount simply to a bidding process, whereby the winner "purchased the . . . [hospital's] economic power and used it as a partial substitute for competitive merit in gaining a major share of the . . . [anesthesiology] market." *Federal Trade Commission v. Texaco, Inc.*, *supra*, 393 U.S. at 230. Indeed, the bidding would be for a monopoly of an *entire* relevant anesthesiology market.[31] Since such markets admit of feasible direct competition, however, there is no justification under the antitrust laws

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removal of restraints upon competitors." 337 U.S. at 309 (citations omitted).

[30] As the court of appeals recognized below, the capability and character of an anesthesiologist can most meaningfully be evaluated only once he is permitted to practice at the hospital. 686 F.2d at 291.

[31] *See* p. 17 & n.24, *supra*. The process would not be analogous to procompetitive price bidding for the patronage of a *customer*, but rather would be more akin to bribing the owner of a bottleneck facility to grant exclusive rather than equal access to it. *See Hecht v. Pro-Football, Inc.*, *supra*. In this light, the government's suggestion (Brief for the United States as Amicus Curiae [hereinafter "Gov. Br."] at 8, 12 n.15) that the arrangement in this case is somehow equivalent to the requirements contract (for the purchase of fuel by an electric utility) in *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961), is plainly unfounded. The Hospital did not contract for *its* anesthesia requirements, but rather for the requirements of patients using the Hospital. By the same token, the requirements contract in *Tampa* did not result in the imposition of a tying arrangement upon third parties as did the arrangement in this case. The government's reasoning is plainly contradicted by this Court's opinion in the analogous case of *Atlantic Refining Co. v. Federal Trade Commission*, *supra*.

for their willful monopolization through franchising or otherwise.[32]

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[32] Petitioners overreach considerably by suggesting the existence of a strong consensus among lower courts that exclusive contracts presumptively pass antitrust muster. Hosp. Br. at 18-19 n.8. The court in *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982), endorsed the erroneous approach of district court below only in dictum based on a negligible record compiled on a motion for a preliminary injunction. By contrast, the court in *Konik v. Champlain Valley Physicians Hospital Medical Center*, 561 F. Supp. 700 (N.D.N.Y. 1983), followed the opinion of the court of appeals below in holding that an exclusive anesthesiology contract would constitute a *per se* tying violation upon proof that competition among anesthesiologists was thereby restrained, and absent proof of a legitimate, articulated medical reason for the contract which could not be accomplished in a less restrictive manner (as to which the court expressed doubt). The court also endorsed plaintiff's boycott theory, although ruling that summary judgment was premature.

Smith v. Northern Michigan Hospitals, Inc., 1983-1 Tr. Cas. (CCH) ¶ 65,289 (6th Cir. 1983), involved an exclusive contract for emergency room services; the court stressed that patients do not choose practitioners in this context, and that unlike this case, no tying arrangement was alleged or discernible. *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3rd Cir. 1982), *cert. denied*, No. 82-415 (U.S. Nov. 1, 1982), did not involve an exclusive contract; while the hospital imposed exacting standards, it was open to any physician to compete for staff privileges. *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980), reached only the interstate commerce issue under the antitrust laws. In *Harron v. United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976), the court provided no analysis whatsoever in dismissing a claim prior to the decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The state court cases cited by petitioners are either inapposite, *see Rumple v. Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981) (relying on absence of exclusive contract); *Blank v. Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 877, 44 Cal. Rptr. 572 (1965) (physicians exempt from state antitrust law), or unpersuasive upon analysis guided by more recent opinions of this Court. *See* pp. 22, 28, *infra*.

D. The Lack of Any Legitimate Justification for the Exclusive Contract Reinforces the Appropriateness of Per Se Treatment.

The court of appeals had the benefit of the decision in *Arizona v. Maricopa County Medical Society, supra,* where the Court firmly held that, with possible exceptions for bona fide quality of care or ethical considerations (which are not involved here), the health care profession is subject to *per se* antitrust rules no less than any other.[33] The court of appeals nevertheless considered—and rejected—petitioners' purported justifications for the challenged tying arrangement in the context of a narrow affirmative defense which this Court may have left open, *i.e.*, that the tying arrangement is essential to the adequate functioning of the tying product, and to protect the defendant's goodwill therein. As observed by the Court in *Standard Oil Co. v. United States, supra,* 337 U.S. at 306:

> "The justification most often advanced in . . . defense [of tying arrangements]—the protection of the good will of the manufacturer of the tying device—fails in the usual situation because *specification of the type and quality* of the product to be used in connection with the tying device is protection enough. . . ." (emphasis added).[34]

The less restrictive alternative test is thus part and parcel of a proper analysis, and quite clear-cut in application: defendant must show that appropriate quality standards—which admit of fair and open competition—

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[33] The court in *Konik v. Champlain Valley Physicians Hospital Medical Center, supra,* 561 F. Supp. at 712, likewise followed *Maricopa* in holding that *per se* rules apply to an exclusive anesthesiology contract.

[34] *See also Fortner I, supra,* 394 U.S. at 503 ("tying arrangements generally serve no legitimate business purpose that cannot be achieved in some less restrictive way"); *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6 & n.5; *cf. Atlantic Refining Co. v. Federal Trade Commission, supra,* 381 U.S. at 371 (distributional efficiencies do not justify tying arrangement).

are infeasible to meet any significant and legitimate concerns allegedly served by the tying arrangement.

Petitioners fail to meet their burden in this regard for two broad reasons. First, petitioners' proffered justifications—to the extent they are plausible at all—rest on the premise that competition should be displaced in the interest of perceived administrative efficiencies which do not relate significantly either to patient welfare or the good will or competitive position of the Hospital. Such justifications thus constitute "nothing less than a frontal assault on the basic policy of the Sherman Act." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978).[35] Just as importantly, all of petitioners' purported concerns could be met through the use of appropriate, objective criteria for the granting and renewal of hospital staff privileges to anesthesiologists, including a requirement of adherence to appropriate bylaws, rules and regulations of the organized medical staff and anesthesia department designed to assure quality of care and adequate coverage.[36] Indeed, the principal

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[35] *See also* Dolan & Ralston, *supra*, at 748 (such justifications imply "a wholesale repeal of the antitrust laws for the health care industry . . . since all anticompetitive practices in the health care industry invariably are grounded on such notions").

[36] The latter concept underlies a document entitled "The Organization of an Anesthsia Department", adopted by the ASA House of Delegates and attached hereto as Appendix B, which details how an open anesthesiology staff can be operated consistently with continuous, high quality patient care. *See also* Dolan & Ralston, *supra*, at 761 (control of staff privileges is sufficient to achieve hospital's administrative and patient care justifications for exclusive contracts.)

Petitioners' assertion that "either 'open' or 'closed' departments restrict the choice of anesthesiologists to those admitted to practice in the hospital" (Hosp. Br. at 34-35, 44) is plainly misplaced. Admission to an open staff depends upon an applicant's qualifications, willingness and ability to meet objective standards, and thus, unlike an exclusive arrangement, permits fair competition on the basis of individual merit. Indeed, even an employment relationship admits of some competition among individuals for a position.

distinction between an open anesthesia staff and an exclusive franchise in this regard is simply that the latter is comprised of a smaller number of anesthesiologists organized into a non-competitive group.[37]

Both petitioners and the government place special emphasis on the proposition that the exclusive contract promoted the efficient use of nurse anesthetists.[38] But nurse anesthetists are effectively utilized in open departments as well.[39] Moreover, any savings through the use of nurse anesthetists were not passed on to patients or their insurers. *See* Hosp. Br. at 3, 25-26. Finally, while petitioners and the government urge protection of com-

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[37] *See* American Hospital Association Brief at 7, 18-19 ("'the fewer the physicians, the easier it is for a hospital to control quality'"); Nord, *supra*, at 67 (advantage of exclusive contract is the provision of coverage "by a smaller number of anesthesiologists than would exist if the hospital had an open anesthesiology department").

In strongly commending open anesthesia staffs as most conducive to competition and optimal patient care, ASA need not contend that hospitals are necessarily "utilities." The issue presented here is the exclusion of one, eminently qualified anesthesiologist from a hospital at which four anesthesiologists covered twelve operating rooms simultaneously (513 F. Supp. at 538). *Cf. Associated Press v. United States*, *supra*, 326 U.S. at 19. While the utility approach to hospital staff privileges has in fact been employed by state courts, *see* Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 St. Louis U. L. Rev. 452, 461 (1978), the court of appeals opinion below "[did] not test the limits of access to staff privileges." 686 F.2d at 295. Legitimate concern with overcrowding is not at issue here and in any event could be dealt with by raising the standards and encouraging individual competition for the award of staff privileges. *See Robinson v. Magovern*, *supra*; *cf. United States v. Terminal R.R. Ass'n of St. Louis*, 224 U.S. 383, 411 (1912) (bottleneck facilities must be fairly shared).

[38] Hosp. Br. at 24-28; Brief for the United States on Petition for Writ of Certiorari at 10; Gov. Br. at 15 n.19.

[39] *See* Hosp. Br. at 26 n.14; Transcript of May 15, 1980 (morning) at 67-68; Transcript of May 16, 1980 at 95.

petition by non-physician health care providers, Gov. Br. at 15 n. 19; Hosp. Br. at 27, the reality of this case is that fully-qualified anesthesiologists—not nurse anesthetists—are being arbitrarily precluded from practice at the Hospital.[40]

Petitioners also make reference to a standard litany of supposed generic justifications for exclusive contracts which originated in non-antitrust state cases.[41] *See* Hosp. Br. at 23-24. Such justifications are not established in the record before the Court in this case. Chief among them is the implausible claim that an exclusive contract—which *limits* the number of available anesthesiologists—facilitates emergency coverage and flexible scheduling.[42] Dr. Roux testified that he deemed himself professionally bound to be available for coverage regardless

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[40] In point of fact, anesthesiologists do not compete with nurse anesthetists. See p. 7 n.4, *supra; United States v. The American Society of Anesthesiologists, supra,* 473 F. Supp. at 160 n.22. In any event, the antitrust laws protect competition, not competitors. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). The suggestion that anesthesiologists are justifiably excluded from the hospital because their services are more costly than that of the nurse anesthetists ignores the teaching of *Arizona v. Maricopa County Medical Society, supra,* where this Court condemned maximum price-fixing because it provided "the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases . . . . [and] also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs." 102 S. Ct. at 2475.

[41] *See, e.g., Blank v. Palo Alto-Stanford Hospital Center, supra*; *Adler v. Montefiore Hospital Ass'n of W. Pennsylvania*, 53 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974).

[42] It is likewise nonsensical to suggest that an exclusive anesthesiology contract enhances the reputation for excellence of the anesthesiology department, "thus enabling [the hospital] to attract top flight physicians." American Hospital Association Brief at 8-9. It has been observed that surgeons have a strong interest in maximizing the size of a hospital's anesthesiology department. Dolan & Ralston, *supra*, at 715.

of the exclusive contract. 686 F.2d at 288 n.2.[43] Moreover, such professional obligations can be and frequently are incorporated into medical staff bylaws, rules and regulations which physicians are bound to observe as a condition of maintaining staff privileges.

Similarly, the suggestion that an exclusive contract may be justified because, by limiting the number of anesthesiologists, it may facilitate closer monitoring of anesthesiologists, greater repetition and standardization of procedures,[44] easier maintenance of equipment,[45] and reduced exposure to malpractice liability,[46] is suspect; the exclusive contract did not reduce the number of practitioners administering anesthesia at the Hospital, only the number of anesthesiologists.[47] Moreover, each of these purposes appears to have little to do with enhancing competition among either anesthesiologists or hospitals (*e.g.*, "standardized procedures" would displace innovation), and

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[43] Dr. Roux similarly disagreed that having more than one group at the hospital would be chaotic or necessarily detract from the quality of care. *See* Transcript of May 15, 1980 (afternoon) at 12-13, 19, 33-34; *see also* Transcript of May 16, 1980 at 34, 87-88.

[44] There is no reason to expect that an already full-time anesthesiologist would repeat procedures more often under an exclusive contract, as opposed to delegating more procedures to nurse anesthetists.

[45] Anesthesiology, by comparison with pathology and radiology, is not equipment-intensive. *See* p. 8 n.7, *supra*.

[46] "[A]bsent hospital representations as to the quality or laxity in ensuring minimal quality, legal liability of independent contractors is unlikely to be imputed to the hospital." Dolan & Ralston, *supra*, at 761 (citation omitted). *See also* Kissam, Webber, Bigus & Holzgraefe, *supra*, at 607-609; Slawkowski, *supra*. The Hospital's legal responsibility to monitor the nurse anesthetists it employed was certainly greater than for independent staff physicians.

[47] It is noteworthy also that the Hospital reserved no control over the growth of the franchised group of anesthesiologists. *See* Transcript of May 15, 1980 (morning) at 30-32.

could in any event be accomplished through rigorous standards and review in granting hospital privileges, backed by appropriate bylaws, rules and regulations.[48]

II. THE GOVERNMENT'S PROPOSAL FOR RADICAL SURGERY ON THE TYING DOCTRINE IS ILL-CONCEIVED AND SHOULD BE REJECTED.

The government focuses primarily on challenging this Court's well-established tying doctrine rather than on the facts of this case.[49] The government would indeed have this Court take "an abrupt . . . [and] radical departure from current law," Gov. Br. at 7, for which the government offers virtually no authority. The government asserts first that a tying arrangement "cannot have an anticompetitive effect" unless the arrangement results in the elimination of "enough" existing rivals in the tied product market to control price (*i.e.*, a monopoly). Gov. Br. at 25.[50] In fact, however, the tying arrangement in this case did result in the monopolization of the tied product market for anesthesiology services. *See* p. 17, *supra*.

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[48] Thus, additional justifications offered for the exclusive contract, such as the willingness of anesthesiologists to commit themselves to a particular hospital, to undertake supervisory and training responsibilities there, or to "operate as a team" were in fact incorporated into the consideration of individual applications for staff privileges in *Robinson v. Magovern*, *supra*.

[49] The Federal Trade Commission does not join in this effort. Gov. Br. at 7 n.9.

[50] The government's assertion is predicated merely on the broad presumption that tying arrangements involve distribution efficiencies and that the competitive alternatives eliminated may not be as efficient. *Id.* at 22, 25 n.29. However, this case amply supports the Court's long recognition that because any foreclosure in the tied market is rooted in *economic leverage* in the tying market used to effect a *mandatory* joint purchase, *despite* the less restrictive alternatives open to the seller, it can justifiably be presumed to "crippl[e] other companies that are equally, if not more, efficient . . ." *Fortner I*, *supra*, 394 U.S. at 509. *See also*,

The government then asserts that a tying arrangement still cannot be "anticompetitive" unless the supplier also has power to exclude the entry of competitors into the tying product market (*i.e.*, a second monopoly), since he cannot otherwise necessarily, indefinitely and fully exploit consumers in that market. Gov. Br. at 25-26. This case bears out this Court's practical wisdom that even though a supplier falls short of market dominance, he may possess sufficient leverage through market imperfections to preempt choice and extract overcharges to an appreciable extent through a tying arrangement, and that unless strictly dealt with, such arrangements threaten to proliferate and magnify in effect.

Finally, the government advocates that tying arrangements be evaluated under a rule of reason rather than a *per se* standard. In this regard, the government suggests that "[s]ince the anticompetitive potential of tie-ins and exclusive dealing [*i.e.*, requirements] contracts is basically identical, both arrangements should be judged by the same criteria." Gov. Br. at 20. However, buyers may freely choose in their own economic interest to enter into a requirements contract, and any anticompetitive effects are

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e.g., id. at 503; *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6.

At bottom, the government's theory reflects a truncated concept of the role of the antitrust laws, which would remain dormant so long as competition had not been virtually eliminated from the market. However, a greater number of unimpeded competitors fosters more robust competition, greater alternatives, and greater innovation. *See, e.g., Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 4 (in enacting the Sherman Act, Congress established "free and unfettered competition as the rule of trade"); L. Sullivan, HANDBOOK OF THE LAW OF ANTITRUST 447-448 (1977). Indeed, Congress enacted Section 3 of the Clayton Act—specifically prohibiting tying arrangements—to arrest restraints of trade in their incipiency. *See, e.g., International Salt Co. v. United States, supra,* 332 U.S. at 396. The standards under the Sherman Act and Clayton Act appear to be identical in this regard. *See Fortner I, supra,* 394 U.S. at 521 (Fortas, J., dissenting); *Moore v. Jas. H. Matthews & Co.,* 550 F.2d 1207, 1214 (9th Cir. 1977).

limited to the resultant foreclosure of the supplier's competitors from such buyers' patronage. The distinguishing feature of tying arrangements is the use of power in one market to create a double-barreled anticompetitive effect in another market. Tying arrangements not only foreclose competitors from fair access to the second market, but also coerce and exploit customers in that market as well.[51]

In sum, this Court has appropriately recognized the crucial distinction between the situation where a buyer *chooses* to enter into a requirements contract and the situation where the buyer's judgment is preempted by a tying arrangement imposed through the exercise of a seller's economic leverage. It is the very function of the market to make such economic judgments, and it is the salutary purpose of the *per se* prohibition on tying arrangements to protect the functioning of the market in this respect, in lieu of displacing it with the judgment of a court acting under the guise of a rule of reason analysis. Tying arrangements—unlike requirements contracts—inevitably and unnecessarily restrain competition by distorting purchaser decisions.

ASA submits that this is hardly the case in which to reverse thirty-five years of consistent Supreme Court precedent applying the *per se* rule in tying cases. In the circumstances of this case, which involves the administration of lethal drugs to human beings under carefully con-

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[51] *See United States v. Loew's Inc., supra,* 371 U.S. at 44-45; *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6, 10; *Standard Oil Co. of California v. United States, supra,* 337 U.S. at 306-307 (because "[r]equirements contracts . . . may well be of economic advantage to buyers as well as to sellers . . . . the coverage by such contracts of a substantial amount of business affords a weaker basis for the inference that competition may be lessened than would similar coverage by tying clauses . . . ."); *Federal Trade Commission v. Brown Shoe Co., Inc.,* 384 U.S. 316, 321 (1966) ("the central policy of both § 1 of the Sherman Act and § 3 of the Clayton Act [is] against contracts which take away freedom of purchasers to buy in an open market").

trolled conditions, the elimination of competition through a classic tying arrangement is not simply a matter of dollars and cents. It can adversely affect the quality of medical care. ASA believes that in this setting it is particularly important that competition be allowed to reward superior performance and innovation, while exposing the indifference to quality that may too often be the hallmark of a monopoly. By advocating approval of tying arrangements in these circumstances, the government is advocating the abandonment of competition in an important segment of the medical care marketplace. If this is what the government wants, its arguments are properly addressed to Congress, not to this Court. See Arizona v. Maricopa County Medical Society, supra, 102 S. Ct. at 2478-2479.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the court of appeals below and hold that the exclusive contract in this case constituted a *per se* violation of the Sherman Act.

Respectfully submitted,

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July 7, 1983

APPENDIX A

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

STATEMENT OF POLICY

(Amended by House of Delegates on October 16, 1980)

The American Society of Anesthesiologists is a non-profit association of reputable doctors of medicine engaged in the practice of or otherwise especially interested in anesthesiology.

As provided in the Bylaws, the Society holds to the following purposes:

To advance the science and art of anesthesiology and

To stimulate interest and promote progress in the scientific, cultural and economic aspects of the speciality of anesthesiology.

It is the official policy of The American Society of Anesthesiologists, Inc. that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. The Society does not consider the compensation arrangement so chosen to be a matter of professional ethics. In addition, an anesthesiologist's compensation arrangements shall not affect his or her eligibility to attain or retain membership in this Society or any of its component societies.

Since anesthesiology has encountered problems individual to it relating to the quality and standards of patient care, which experience has shown are due in part to the form of compensation arrangements entered into by anesthesiologists, the Society believes that its members should be specifically cognizant of the following principles advocated by it:

I The practice of anesthesiology by a member of the Society is the practice of medicine and is not an institutional "service".

II The sole source of the income of a member of this Society from professional practice should be the service rendered to the patient by the member or under the member's direct, personal and continuous supervision, and for which the patient or the patient's agent is billed directly.

III A member of this Society should not enter into or remain in any relationship whereby the member's professional services are offered for a fee. This should not be construed to preclude the organization of physicians into groups in the form of professional corporations or associations having the characteristics of corporations, where such organizations are specifically permitted by law, and where ownership and management are—and are required either by law or contract to remain—exclusively in the hands of physicians. Further, a stipend may properly be accepted for teaching or administrative duties, or for service to non-pay patients, if the number of such patients is great enough to require it.

IV Exploitation of anesthesiologists by other anesthesiologists is improper. For example, in group practice, after a short trial period to determine acceptability, each anesthesiologist should generally receive income that is relatively proportionate to the service rendered for the group.

V Exploitation of physicians-in-training is improper. When an anesthesiologist supervises the administration of anesthesia by a physician-in-training to private patients or renders some lesser portion of the anesthetic care of such patient, fees charged should be commensurate with the services provided by the directing anesthesiologist.

VI Contracts, arrangements, or agreements between a hospital and an anesthesiologist or a group of anesthesiologists, or between anesthesiolgists themselves, whether establishing an exclusive or other form of practice arrangement, should not restrict a patient's access to quality medical care or limit the optimal utilization of hospital facilities, by preventing qualified physicians who might otherwise desire to, or be acceptable for, practice in the institution from securing staff appointments in and practicing anesthesia. Where a hospital's other clinical departments have open medical staffs, an otherwise qualified anesthesiologist, willing to share in the responsibilities for providing necessary anesthesia service, should not have to become part of any specific group or have any specific financial relationship with the hospital or with another physician as a condition to becoming a member of the staff of the hospital, or as a condition to participate in the provision of anesthesia care, free of arbitrary restraint.

This Statement of Policy contains principles formally adopted by and strongly advocated by this Society. Neither acceptance of nor adherence to this Statement of Policy is a condition of any privilege of membership in the Society and the adoption and publication of this Statement of Policy is not intended to interfere with any member's exercise of independent judgment. Each member of the Society, however, is urged to consider the principles stated herein as they apply to the member's own medical practice.

APPENDIX B

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

THE ORGANIZATION OF AN ANESTHESIA DEPARTMENT

(Approved by House of Delegates on October 26, 1982)

Experience has shown that anesthesiology has encountered problems individual to it relating to the quality and standards of patient care which are due in part to practice arrangements between hospitals and anesthesiologists and between anesthesiologists themselves. In response to these problems, The American Society of Anesthesiologists has adopted a *Statement of Policy* which contains principles which the Society urges its members to consider in structuring their own individual medical practices.*

Provision of quality anesthesia care for the patient requires that individual medical practices within the context of the individual hospital be organized for administrative purposes into a functioning entity, or department, which is managed and operated in a manner which will facilitate the patient's access to quality anesthesia care and promote the efficient fulfillment of the responsibilities of individual physicians and the hospital's administration to the patient and the community. Because of the diversity of local conditions, no single framework for the organization and management of a department of anesthesia which is suited to all situations can be recommended. However, the organization of the department of anesthesia should be consistent with the organization of

* It is the official policy of the Society that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. The Society does not consider the compensation arrangement so chosen to be a matter of professional ethics.

the hospital's other clinical departments and should assure the availability of quality anesthesia care where and when needed in the hospital. In addition, the following suggestions should be considered in addressing the practical problems of organizing and managing an anesthesia department which has quality patient care as its primary goal.

I. PHYSICIAN RESPONSIBILITIES FOR MEDICAL CARE

Since the quality of care in anesthesia depends in large measure upon the role of the physician in rendering such care, the proper definition of the responsibilities of individual physicians in the provision of medical care is the starting point in the organization of an anesthesia department. Such definition should take into account the following principles:

A. Anesthesia care is the practice of medicine. An anesthesiologist must be personally responsible to each patient for the provision of anesthesia care.

B. The anesthesiologist's responsibilities to the patient should include responsibility for preanesthetic evaluation and care, medical management of the anesthetic procedure and of the patient during surgery, post-anesthetic evaluation and care, and medical direction of any nonphysician who assists in providing anesthesia care to the patient. The anesthesiologist should fulfill his responsibilities to the patient in accordance with the ASA *Guidelines to the Ethical Practice of Anesthesiology* and *Guidelines for Patient Care in Anesthesiology.*

C. An anesthesiologist exercises the same independent medical judgment on behalf of the patient as is exercised by other physicians. When rendering medical care to a particular patient, an anesthesi-

ologist is not working for, or as the agent of, the hospital, nor is the anesthesiologist discharging an institutional responsibility. Accordingly, the hospital should not be responsible for the proper performance of this care, and should not direct or control the manner in which it is performed.

D. As a member of the hospital medical staff, an anesthesiologist is subject to and must observe, as well as be accorded the benefits of, the medical staff bylaws, rules and regulations generally applicable to all physicians granted privileges in the hospital. Additional rights and responsibilities may arise from rules and regulations specifically applicable to physicians in the department of anesthesia.

E. An anesthesiologist with full staff privileges must share on a fair and equitable basis in the responsibility for assuring 24-hour a day, 7-day a week availability of anesthesia care.

II. MEDICO-ADMINISTRATIVE ORGANIZATION AND RESPONSIBILITES

The department of anesthesia has the responsibility to promote and ensure patient access to quality care in anesthesia and the optimal utilization of hospital facilities. To fulfill this responsibility, it is necessary, but not in itself sufficient, to grant staff privileges to all qualified physicians who desire to practice anesthesia in the hospital and who are committed to fulfilling individual physician responsibilities for medical care. Additionally, the anesthesia department must develop a practicable system which will assure the constant personal availability of a member of the department. The department must also monitor and enforce adherence to standards of care, the medical staff bylaws and the rules and regula-

tions particularly applicable to the anesthesia staff. The discharge of these administrative responsibilities should be guided by the following principles:

A. The assumption and performance of medico-administrative responsibilities, though for the ultimate benefit of patients, are undertaken on behalf of, and as the agent for, the hospital. The fact that a physician has medico-administrative responsibilities should not affect his, or any other physician's, individual responsibilities to patients or his rights under the medical staff bylaws.

B. All members of the staff should share in the discharge of medico-administrative responsibilities to the extent necessary or appropriate.

C. Administration of the anesthesia department should be directed by a qualified anesthesiologist member of the medical staff. The director should be elected or appointed in the same manner as the directors of the other clinical departments in the hospital.

D. The director of the anesthesia department should be responsible for the following medico-administrative functions in a manner similar to directors of other clinical departments.

   1. Recommending clinical privileges for all individuals with primary anesthesia responsibilities. Privileges should be processed through established medical staff channels, be based solely on qualifications and competence, and be conditioned upon observance of the medical staff bylaws and the rules and regulations governing the anesthesia department. Privileges should be delineated in accordance with the ASA *Guidelines for Delineation of Privileges in Anesthesiology* and the *Suggestions*

to ASA Members for Delineation of Anesthesia Functions for Non-Physician Personnel.

2. Monitoring the quality of anesthesia care rendered throughout the hospital, including surgical, obstetrical, emergency, outpatient, psychiatric and special procedural areas. The ASA *Suggestions for a Record of Anesthesia Care to Facilitate Medical Audit* should be followed in order to provide the factual basis for such monitoring.

3. Recommending to the hospital administration and medical staff the type and amount of equipment and supplies necessary for administering anesthesia and for resuscitation.

4. Developing regulations concerning anesthetic safety.

5. Ensuring evaluation of the quality of anesthesia care throughout the hospital. Such evaluation should be based on the ASA *Guidelines for Peer Review in Anesthesiology.*

6. Establishing a program of continuing education for all personnel having anesthesia privileges, such program to include in-service training and to be based in part on the results of the evaluation of anesthesia care. Such program should follow the ASA *Guidelines for a Minimal Acceptable Program of Any Continuing Education Requirement.*

7. Participating in the development of, and enforcing, policies and procedures relating to the functioning of anesthesia personnel and the administration of anesthesia throughout the hospital.

8. Ensuring that qualified anesthesia personnel are available for the daily surgical schedule

and providing a schedule for 24-hour, 7-day a week availability of anesthesia care. Scheduling may be coordinated by the director or may be accomplished directly by scheduling between surgeons and anesthesiologists or indirectly by surgeons through the person responsible for developing the surgical schedule. Any scheduling mechanism should accommodate patient requests for specific anesthesiologists.

E. A description of the details of the operation of the anesthesia department, including all policies and procedures applicable to personnel in the department, should be compiled in a single set of rules and regulations or in a procedure and policy manual. Such policies and procedures must be consistent with the medical staff bylaws, the hospital charter and administrative regulations and local law, and should be based upon the ASA *Anesthesia Services: Procedure and Policy Manual* and other ASA guidelines and suggestions, adapted to suit local conditions.

In any event, the department of anesthesia must not be operated in a manner which restricts the patient's access to quality care or inhibits the competitive development of the specialty of anesthesiology.